

Tuberculosis (TB) Treatment Contract

Name _____	Date ____/____/____
Street Address _____	City _____ Zip _____
Home Phone (____) ____ - ____	Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

It has come to our attention based on current health records that you have active pulmonary **tuberculosis**, which is a serious disease requiring medical treatment to keep it from spreading to other people. It is important you read all the information contained in this contract and recognize the state of Colorado, under the law CRS 25-4-501, requires you to

1. Keep all appointments with doctors and clinics as instructed;
2. Follow all medical instructions from clinic staff and/or your physician regarding treatment for your tuberculosis;
3. Arrive on time when you have appointments for directly observed therapy at the Public Health Department Clinic; with clinic outreach staff; or at another clinic that is approved under this contract;
4. Not return to work or school until authorized by your public health agency;
5. Not allow anyone other than those living with you or health department staff into your home until you receive permission from your public health agency;
6. Not leave your home except as authorized by your public health agency;
7. Follow any special orders on the backside of this contract.

You must understand, initial and follow the instructions on the back of this contract.

This contract shall be in effect until you no longer need treatment for **tuberculosis**.

If you fail to do what is required under this contract, you will receive spoken and/or written warnings requesting that you receive your medical treatment. If you fail to follow this contract, you may receive a written order to remain in isolation according to Colorado state law CRS 25-4-507 (see attachment A). Failure to do what this written order requires you to do will result in a court order under Colorado laws CRS 25-1-112 and 512, which you must obey or you will be charged with a misdemeanor criminal offense under law CRS 25-1-114(4). The purpose of this contract is to protect the public health.

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Client's Name _____ Date _____

Physician's Name _____

Please initial below where indicated.

1. I will keep all appointments given to me by clinical staff. I am aware the duration of treatment for tuberculosis is typically for six or more months. I understand that ongoing appointments will be necessary for the duration of treatment to ensure my treatment is working. _____
(initial)
2. I will follow my tuberculosis treatment plan. This means I will (1) take all medications for the treatment of tuberculosis as prescribed by my doctor or other clinic staff, (2) provide sputum, urine or blood specimens as requested, (3) receive chest X-ray tests as requested, (4) report changes in my health, (5) report any changes in my contact information, and (6) provide information about the people with whom I spend a lot of time. _____
(initial)
3. I will arrive as scheduled to the Public Health Department Clinic or another clinic that is approved under this contract for directly observed therapy to make sure that I take all the medication needed to cure my tuberculosis. Taking directly observed therapy means that a health care worker will meet me at a scheduled time and place and give me the medication ordered by the doctor. Participating in directly observed therapy will give me the best chance to cure my tuberculosis. Alternate location for directly observed therapy _____ / _____.
(location) (initial)
4. I will not return to work or school until I have permission from my public health agency. _____
(initial)
5. I will not allow anyone other than health department staff or those already living with me into my home until authorized. _____
(initial)
6. I will not leave my home until I have permission from my public health agency. _____
(initial)
- ☐ Because I could spread tuberculosis to others, I will remain in my home or in a place where I will not expose others to the tuberculosis germs. When I take my tuberculosis medications, I will decrease the chance of spreading tuberculosis to others. My public health agency will decide when it is safe for me to return to school and/or work at my follow-up appointments.
_____/_____
(initial) (date)
- ☐ I may attend school and/or go to work. _____ / _____.
(initial) (date)

7. Special orders _____

I hereby acknowledge that I received a copy of this contract and understand the requirements in it.

Signed _____ **Date** _____
(Signature)

Witness _____ **Date** _____

If interpreter was used:

Interpreter Name/ID number: _____

Agency: _____